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# Transition to motherhood in women with eating disorders: A qualitative study

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## Abstract

**Objectives:** The aim of this study was to examine in depth the individual experience of transition from pregnancy to motherhood, among women with current eating disorders (ED), focusing on differences between the first and subsequent pregnancies. **Design and Methods:** We analysed the narratives of 12 women with severe ED during pregnancy using Interpretative Phenomenological Analysis (IPA). We employed a sequential structure and the emerging themes were ordered according to consecutive pregnancy stages. **Results:** Our results indicate that experiences of pregnancy vary across pregnancy stages and in the first pregnancy compared to subsequent pregnancies. In particular, during their first pregnancy women with an ED seem to experience an inner conflict and questioned the continuity of their ED identity leading them to be more open to change. **Conclusions:** The first pregnancy, during its early stages, should be considered a potentially unique window for intervention for women with current ED.

### **Practitioner points**

- \* Our novel findings indicate that experiences of pregnancy in women with ED vary across pregnancy stages and in the first pregnancy compared to subsequent pregnancies. In particular, during their first pregnancy women with an ED are more likely to question the continuity of their ED identity.
- \* We also found that in early stages of pregnancy women with ED felt more vulnerable: on the one hand they felt compelled to relinquish their ED identity, on the other, they were not yet identified with the mother-to be identity (Mason, Cooper, & Turner, 2012) and felt uncomfortable with their bodily changes. This could be an important window for intervention as women with ED seem more likely to seek for help and are motivated to challenge their behaviours. This especially appears to be the case for primigravidae.
- \* Our findings have also important implications in understanding mechanisms of relapse in the post-partum period, which could ultimately help in developing a tailored intervention for women with ED in their journey to motherhood. Supporting women with ED in relation to their internal and external demands, and realistically preparing them for the challenges of the post-partum period, could ultimately help to prevent ED relapse.

## **Introduction**

Eating Disorders (ED) affect about 8% of women during pregnancy (Easter et al., 2013). Anorexia Nervosa (AN) and Bulimia Nervosa (BN) cause amenorrhea, irregular menstruation, and alteration of the normal hormonal balance, leading to fertility problems (Brinch, Isager, & Tolstrup, 1988; Crow, Agras, Crosby, Halmi, & Mitchell, 2008; Easter, Treasure, & Micali, 2011; Micali, Northstone, Emmett, Naumann, & Treasure, 2012); but a proportion of women with ED do become pregnant.

Although ED symptoms are known to decrease during pregnancy (Bonne, Rubinoff, & Berry, 1996; Blais et al., 2000; Lacey, 1983; Bulik et al., 2007; Micali, Simonoff, & Treasure, 2007; Crow et al., 2008) recent studies have highlighted how ED cognitions and behaviours persist throughout the course of pregnancy (Micali, Simonoff, et al., 2007), and are associated with higher levels of anxiety and depression (Mazzeo, Zucker, Gerke, Mitchell, & Bulik, 2005; Micali, Treasure, & Simonoff, 2007).

The post-partum on the other hand has been shown to be a vulnerable period for women with ED, as demonstrated by the high incidence of symptomatic relapse of in women with ED (Blais et al., 2000; Crow et al., 2008). Improved understanding of the psychological adaptations that women with ED experience during the perinatal period, could ultimately inform the development of supportive interventions targeted at women with ED in the perinatal period.

### *Qualitative studies on pregnancy*

Pregnancy is a unique experience in a woman's life in terms of the profound changes on the self and the body, implicated in this process (Young, 1984). During this process women are exposed to profound and rapid changes involving their sense of identity and body, as explored in the work of many authors (Bailey, 1999; Smith, 1999b; Smith, 1999a; Earle, 2000; Upton & Han, 2003; Schmied & Lupton, 2001), possibly resulting in a sense of loss and uncertainty (Smith, 1999b; Upton, 2003).

Bailey (1999), in her qualitative study, describes how women during pregnancy reported an "altered" sense of self, expressed by both the body and their self-identity, which the author terms a "refraction"

of the self. This concept is similarly described in Barclay's work (1999) and Earle's work (2000), where the authors describe how women perceive a loss of their self-identity during pregnancy and feel left with a sense of inadequacy. The difficulty in identifying an "internal self" during the experience of pregnancy, when women are challenged to individuate the foetus as a separate identity from their body is explored by Schmied and Lupton (2003). Upton (2003) focused primarily on the feeling of loss of the 'body-self', which in the post-partum period is replaced by the feeling of loss of the pregnant body. She stresses that while pregnancy represents a 'liminal state of being', the post-partum might represent a period when women endeavour to regain their pre-pregnancy body, in an attempt to reintegrate the body and the self. Smith (1999a) highlights two phases of transition in the development of the self towards motherhood: a first phase of inward withdrawal and a second phase of opening to social connections, highlighting the importance of social connections and environment in pregnancy.

#### Qualitative studies on pregnancy and Eating Disorders

Over-evaluation of body-weight and shape are central to ED. ED have also been thought to be associated with problems in identity development (Bruch, 1982; Strober, 1991; Piran, 2001; Stein & Corte, 2007), characterised by an impaired capacity in identifying feelings and differentiating between feelings and bodily sensations (Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004; Lilenfeld, Wonderlich, Riso, Crosby, & Mitchell, 2006; Matsumoto et al., 2006; Pollatos et al., 2008; Eshkevari, Rieger, Longo, Haggard, & Treasure, 2012). Another feature of ED pathology, as shown in a recent meta-analysis (Caglar-Nazali et al., 2013) is linked to likely impairment of social processing, characterized by decreased social and emotional functioning. Changes in self-identity, body-identity and relationships with others occurring during pregnancy are therefore likely to be particularly challenging for women affected by ED.

Only a handful of qualitative studies have been conducted exploring the experience of pregnancy in women with ED. Tierney et al. (Tierney, Fox, Butterfield, Stringer, & Furber, 2011) described how women with ED seem to be caught between opposite loyalties (between their ED and the future baby's demands) during pregnancy. A study of women with AN (Mason, Cooper and Turner, 2012) highlighted the theme of "new meaning of embodiment", which the authors define as a difficulty in adapting to a new status and the emergence of a new relationship with the body during pregnancy. Other studies have focused on one particular aspect of motherhood, such as the post-partum period (Patel, Lee, Wheatcroft, Barnes, & Stein, 2005) and found that women with ED reported being highly distressed by the intensity of body and shape concerns, or breastfeeding (Stapleton, Fielder and Kirham, 2008). Women with ED were caught in between the new-born's needs and the 'needs' of their ED. Almost all the studies focused on primiparae or did not differentiate the first from subsequent pregnancies.

In the present study we aimed to investigate the experience of pregnancy in women with ED in depth. Based on previous qualitative literature we aimed to particularly focus on women's individual experiences, their relationship with their changing bodies and the process of becoming mothers during pregnancy and into the post-partum period. We also aimed to understand whether their experiences were different in the first pregnancy compared to subsequent pregnancies.

## **Methods**

### *Participants*

Participants were identified through two strategies: 1) Women involved in a longitudinal study of ED in pregnancy, recruited via the Perinatal Psychiatry and Maternity Unit at King's College Hospital and 2) Women referred or in treatment for an ED at ED specialist services at the ED Specialist service, South London and Maudsley NHS Trust, London, UK.

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Inclusion criteria were: DSM-IV ED diagnosis during pregnancy; age between 18-40, youngest child between 8 months and 2 years old. Exclusion criteria were any chronic physical disorder and any psychotic symptoms. We chose to include women whose children were aged 8 months to 2 years given evidence that participants are more able to access and reflect on their memories and experiences of pregnancy only retrospectively.

Those who expressed an interest in taking part in this qualitative study (N=12) were contacted by phone by one of the researchers (AE, ET); they were then explained the study and informed consent was sought. All 12 participants agreed to take part in the study and were included.

### **Ethical approval**

This study was approved by The Joint South London and the Institute of Psychiatry NHS Research Ethics Committee' (Ref. 09/H0807/12).

### **Procedures: Data collection**

Interpretative Phenomenological Analysis (IPA) was chosen for data collection and analysis. IPA is a phenomenological approach but also hermeneutic and idiographic, as described by Smith (Smith et al., 2009).

IPA was chosen, as it focuses on the individual's encounter with phenomenological reality and the individual's account of his/her own experience (interpretative). The researcher plays a central role in the process as he/she is required to interpret the material using his/her own theoretical position (known as a double hermeneutic approach).

IPA in contrast to a nomothetic approach, is concerned with the individual, seen as a unique agent with a unique life history (idiographic approach), within particular context of time and space, within an in depth and detailed analysis. For this reason it requires a small sample of participants ('about ten') (Smith et al., 2009).

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This study utilised semi-structured, face-to face, individual interviews, generally at the participant's house. Informed consent was sought and obtained for all the participants. Each interview lasted between 30 and 90 minutes. An initial topic guide was devised by the authors, based on an extensive literature review. The topic guide was modified dynamically and shaped following on from participants' interviews.

Women were asked open-ended questions to encourage them to talk in detail about their relationship with food and with their bodies. Further questions were included to explore changes occurring during the first pregnancy, in relation to eating and bodily changes. Women's feelings after the birth and in the post-partum period were also explored in depth. Prompts were used during the interview in order to gain a deeper understanding of the interpretation that participants made of their own experience. Finally, we asked participants to account for any difference between the first and subsequent pregnancies, if they were multiparous. As suggested by Smith et al. (2009) the interviews were all audio-recorded and transcribed verbatim prior to analysis.

### Data analysis

Data analysis was conducted in line with the principles of IPA (Smith, 2009). Two researchers (ET, AE) initially analysed all transcripts separately. An initial stage of the analyses was undertaken to explore semantic content and language use. The type of comments used to analyse the text were of three types: descriptive, linguistic and conceptual (Smith et al, 2009). A second stage was carried out on all the transcripts by individuating emerging themes and lastly organizing them in "key themes". A case-study was also written up for each participant: information and elements from the text referring to the various different states lived through the course of pregnancy were written so to constitute a "story" for each participant. At the final stage the two researchers met to discuss their analyses and key themes. All themes were included and then grouped in subordinate themes from which super-ordinate themes were extracted after several consultations between researchers and the senior author (NM). We employed a sequential structure, as chosen by Smith (1999a) in his qualitative



analysis of women's experiences during pregnancy: the emerging themes were ordered according to consecutive pregnancy stages (early-middle-late pregnancy, postpartum). This allowed to specifically look at the evolution of identity through the course of gestation and to relate the postpartum experience to previous stages.

The final step of the analysis encompasses abstracting and formulating interpretations. This process has to be "grounded" in the participants' experience (hermeneutic of empathy, Smith 2009) but also requires the researcher to take a step back and inquire the material (hermeneutic of suspicion, Smith, 2009). The interpretation process must also take into account the researcher's background. However he/she needs to remain self-critical, in a process of self-questioning his/her position. The researchers involved in the analysis undertaken in this study were from psychiatric and psychological backgrounds, and have clinical and research experience both in ED and mother-baby domains. In particular, consultation between researchers and with the senior author allowed self-reflectivity and taking into account different backgrounds.

## **Results**

### Participants

Twelve women took part and were included in the study. Characteristics and details on participants' recruitment, diagnoses and socio-demographic data are shown in Table 1.

### TABLE 1 ABOUT HERE

### Themes

A table listing all the themes is available below (Table 2). Five super-ordinate themes were identified: 1) Approaching pregnancy: Not expecting to be pregnant; 2) Early Pregnancy: A difficult transition, Making space for the baby: the sacrifice of the ED identity; 3) Middle to late pregnancy: Assuming the

pregnancy identity, a new body to love; 4) Post-partum: Loss of the pre-pregnancy body-identity, loss of pregnant-identity 5) Other pregnancies

## TABLE 2 ABOUT HERE

### Approaching pregnancy:

#### 1) Not expecting to be pregnant

Many participants (nine out of twelve) mentioned that the pregnancy was unplanned. They either had not expected to get pregnant or they got pregnant more quickly than they expected. The news usually triggered mixed feelings: on the one hand, relief about the sudden realization of being able to conceive, on the other hand preoccupation with the upcoming changes. For two women, both of whom were very young at the time, the event was difficult and disruptive to other aspects of their lives. Participant one found it quite hard to believe she was pregnant: “*I didn’t expect it, as I didn’t have my period for a long time, and I was taking the pill, I think I felt like a shock...*” At the time of discovering her pregnancy, participant two had only just started to receive psychological treatment for her ED: “*it was difficult, there were still issues I really had to deal with, issues to go through but I didn’t have time as (...) I found out I was pregnant. I mean I was, I was devastated I couldn’t cope with it very well...*”

Only three participants had actively planned their pregnancies. In these interviews the idea of becoming pregnant was described as an important aspect of their relationship with their ED, which was highlighted in one case a “curative” role of the pregnancy.

### Early pregnancy

#### 1) A difficult transition

Several of the participants in the present study found the beginning of pregnancy quite stressful, both due to changes in appetite and body shape, which they described as evident to themselves but not yet clearly identifiable by others as pregnancy-related changes.

Some of the participants whose self-esteem and sense of self very much relied upon their thin body, found these initial changes during pregnancy highly anxiety provoking, perceiving them as a loss of control over their body and sense of self. *"I found it really hard that my body was changing and I changed quite quickly and I compared myself to women who don't change that quickly and that again was a good stick to beat myself with"* (Participant three). The experience was so distressing that it prompted her to seek treatment for her ED for the first time after a long history of ED.

Participant four, described the difficult feelings she experienced towards the changes in her body during early pregnancy: *"I was weighing myself lots...it was very difficult the first three months (...) when I became pregnant I hated it (long pause); first because I felt fat, and then because my clothes stopped fitting. It just makes you feel worse. I felt just absolutely grotesque. Then only when my bump started showing...it began to feel more real"*.

It appears from these transcripts that difficulties in early pregnancy are related to women losing their body shape and starting to gain weight, prior to acquiring a new "pregnancy identity" that is obvious to the onlooker.

## 2) Making space for the baby, sacrificing the ED identity

In our study the participants recognized ED behaviours as a part of their pre-pregnancy identity. For all the women in this study their disordered eating began in their early pubertal years, therefore they described how the ED had been a constant presence in their life. Pregnancy represented a point when their ED, an integral part of their identity, became questioned. Women seemed to feel pressure to reassess a part of their own self that was felt to be unacceptable and incompatible with being pregnant.

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Participant two described the complexity of having to balance her pregnancy and her ED, which was a: *“a massive part of my identity, and it still is. A person who is strange with food. When I got pregnant I didn’t have time to sort out my issues, but I told myself ‘we have to fix it now because if you don’t you are not going to be able to do this.’”*

Participant five underwent fertility treatment in order to conceive her pregnancy. For this participant, the ED (identified as a part of the self) represented something that was not tolerated by others (society), and incompatible with receiving fertility treatment: *“there were people, there were a couple of people saying that I had to be eating properly because I have been given the chance to have the (fertility) treatment: so I had to eat properly! So I did kind of made sure I was eating properly”*.

For the majority of women the need for discontinuity and breaking with their ED history was a pivotal point in the early stages of their pregnancy. Nevertheless, the wish for an immediate change to take place often led to an unrealistic expectation of immediate recovery: *“I just basically stopped being sick immediately...after actually things having been quite bad before I realized. As soon as I knew I just stopped, after actually things have been quite bad before I realized. As soon as I knew I just stopped”* (Participant six). The use of the word ‘immediately’ here emphasises the perceived urgency of such a transformation. These expectations could also be thought in relation to perfectionistic traits (associated with the ED), as shown in the following quote *“I wanted so much to be the ideal pregnant person”* (Participant six).

The direct consequence of the pressure to immediately relinquish all ED related behaviours during pregnancy frequently resulted in disappointment when symptoms returned in the post-partum.

Participant seven, a woman in her thirties suffering from BN for which she never sought treatment, was able to completely stop bingeing and purging during pregnancy, but relapsed shortly after: *“it came back, as it always did in my life... and each time it comes back I get so disappointed.”*

#### Middle to late pregnancy

1) Assuming the pregnancy identity: a new body to love

In the later stages of pregnancy the participants' narrative suggests that they became more comfortable with their pregnancy identity and established a stronger connection with their baby. Participants spoke about a fear of harming their baby by engaging in ED behaviours and a desire to act in the best interest of the baby. As a consequence, almost all of the participants either attempted to or succeeded in reducing their ED behaviours in middle and late pregnancy. Some of the women who restricted their dietary intake prior to pregnancy tried to rationalize the decrease in their disordered eating behaviours ascribing it to "*hormonal changes*" during pregnancy, which resulted in increases of appetite and facilitated a better relationship with food.

For some of the women breaking unhealthy eating habits helped to secure healthier eating patterns. Feeling in a "good place" or having an "improved relationship with food" is recurrent throughout the interviews. Nevertheless in some cases it emerges that this was more of an internal feeling and despite some minor improvements, symptoms (mostly restriction) were still present. Again, there is a discrepancy between what the women expected to happen and what in reality does happen. Despite this contradiction later in pregnancy, for the majority of women their bodies developed, in their eyes, a different meaning: the tool to nourish and look after their baby.

*"I didn't mind how I looked when I was pregnant (...) I was more comfortable because you have a reason people will see you pregnant and they won't think 'oh my god she's really fat' they just think 'she's just pregnant'" (Participant eight).*

Participant two who described feeling as if she was "separated" and "against" her body throughout her life describes: *"When I got pregnant suddenly we had to start working together and suddenly I was seeing that actually it (her body) could do things right it could do things that everybody said it would never be able to do."*

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Regarding the relationship with the external world, the women in our study positively embraced the new 'pregnant self', in particular in respect to how they fitted into society, as shown in the following quotes: *"I was proud of my bump"; "they will think I am just pregnant, not thin or fat"; "I think being pregnant was a more acceptable aim at my age"*.

Participant four who went from being disgusted by her body to being proud of it reported: "People were giving me so many compliments (...) I started believing it."

These descriptions could be interpreted as the participants feeling rewarded by the social recognition of their pregnant status, which helped them to feel better about themselves.

#### Post-partum: transition to motherhood

##### 1. Loss of the pre-pregnancy body-identity, loss of pregnant-identity

The majority of women in this study expressed high levels of distress related to their body shape in the post-partum. In contrast to the narrative used to describe their feelings towards their bodies in middle-late pregnancy there is a stark change in the language used as the participants begin to refer to their body as *"very big"* *"disgusting"*, and *"falling apart"* in the post-partum.

Most of the women interviewed began to feel uncomfortable with the weight they gained during pregnancy and described how the urge to lose weight after the birth became compelling.

Participant number nine who gained minimal weight during pregnancy says: *"after (the baby) was born all I wanted to do was lose weight as quickly as possible"*. Other participants were less open about how actively they tried to lose weight but they reported it happening suddenly. The women who binge-purged prior to pregnancy, all reported a relapse in their ED during the first months after the birth.

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The loss of the pre-pregnant self and the experience of being left with a non-familiar body, while becoming familiar with the new identity as a mother, seem to create a sense of vulnerability. As described by participant number ten: *“This is what I am going to be like forever, this is awful, I look awful, what I am going to do, I sat and cried in the bath thinking I look disgusting”*.

Nevertheless, the mothers seemed to be particularly sensitive to the loss of the pregnant-self, which although known to be transient had been greatly invested in by some of the participants.

During the transitional phase of motherhood, while women are adapting to their new maternal role, losing their pregnant identity seemed particularly difficult for some of the participants in this study. For example, participant number four, who previously described an ‘*idyllic*’ late pregnancy, spoke about the effect that giving birth had on her body as a traumatic experience *“as soon as I gave birth I was absolutely horrified by my body (...) I thought -I looked like an alien, your body is completely falling apart- It was such a shock ... for several weeks I felt really miserable and I wasn’t really prepared for that.”*

Of particular interest is the experience of participant twelve who had extreme difficulties coping with the loss of her pregnant self, which for her reflected a temporary period of “remission” after many years of illness. *“I was sustaining a normal life; but it was based on being pregnant”*. Having to face the demands that her new role as mother required, she found the extreme solution of becoming pregnant again for seven consecutive times: *“ I spent all my life being severely anorexic, I didn’t know how to cope (...) I knew if I had got pregnant again I would escape that hole, I would manage. So I did. And I repeated it for the following ten years.”*

This transcript is emblematic as it outlines, although in dramatic and extreme terms, how pregnancy can represent a temporary relief from their illness for women with ED that can lead to higher expectations of recovery on the part of women and their families.

#### Subsequent pregnancies

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We specifically asked the four participants who had more than one child to reflect on any potential differences and similarities between the first and their later pregnancies.

It emerged that all the participants interviewed had a very different experience during their subsequent pregnancies compared to their first.

The main difference the women interviewed reported was in terms of motivation and drive for change. In the later pregnancies these mothers did not feel the same pressure to relinquish their ED identities for their pregnant selves as they did in their first pregnancy. The coexistence of being pregnant and having an ED, which appeared to create cognitive dissonance during the first pregnancy, was accepted in the following pregnancies.

This for Participant eight was related to the previous post-partum experience, as she was now conscious she would have to be faced with a weight that was uncomfortable for her after birth.

During her first pregnancy she reported having felt as if it was *“the only time I had a sort of normal relationship with food”* and that she *“didn’t bother about the weight gain”* (participant eight). During the second pregnancy, she engaged in ED behaviours and was much more aware of her weight compared to her first pregnancy. Reflecting on her experiences during her second pregnancy she said: *“I didn’t eat as much, this time, and I was more aware of that little anorexic voice this time and a couple of times I purged and stuff (....) I didn’t like my pregnant body, whilst I liked being pregnant with (first baby) and I enjoyed being big because I was pregnant”*. Her account of this difference is related to her first post-partum experience: *“(This time) I knew I was going to get big, I’d been through the experience before, so I was going to have to get big and then put a lot of effort into losing all that weight again”*. During her first pregnancy her main motivation to change her ED behaviours was her worry about harming the baby. The reassurance of having given birth to a healthy baby the first time seemed to demotivate her to change her behaviours in subsequent pregnancies.



Participant four who described the first pregnancy as a “rest” from her ED, reported that she weighed herself every day during the second pregnancy. Similarly, during her first pregnancy participant nine tried her best to achieve a higher BMI in order to conceive; this did not happen in the following pregnancies, when she sought fertility treatment.

## **Discussion**

Our results highlight a primary difficulty for women with ED in dealing with the early stage of pregnancy. Early pregnancy was experienced as incompatible with a consistent part of their selves, their ED identity. Later stages of pregnancy were characterized by a temporary identification with a more socially accepted ‘pregnant-self’, which allowed some women to experience a new reconnection to their body. This period of remission seemed to be challenged by the powerful changes occurring in the post-partum period. In the post-partum women with ED are faced with the sudden loss of their pregnant body, and they tend to turn to old coping mechanisms (such as restricting or purging). A different scenario is pictured by the same women in subsequent pregnancies, when the ED is more prominent throughout the pregnancy.

The majority of pregnancies in this particular sample were unplanned, and it emerged that participants approached pregnancy with mixed feelings. These data enriches in a qualitative way, the results from previous epidemiological studies that have identified higher rates of unintentional pregnancies among women with AN (Bulik et al., 2010; Easter, Treasure, Micali, 2011; Micali et al. 2013) and higher levels of mixed feelings upon discovering their pregnancy in women with ED compared to controls (Easter et al. 2011; Micali et al., 2013). The mothers in the present study expressed incredulity and surprise to learn they were able to get pregnant; for some of them it was a relief, for others a ‘shock’.

A possible explanation is that the lack of menstruation and menstrual irregularity common among women with ED, which results in uncertainty as to whether they are able to conceive or not. Alternatively, it also could be linked to the delicate relationship with sexuality that women with ED

seem to have (Beumont, Abraham, & Simson, 1981; Haimes & Katz, 1988; Heavey, Parker, Bhat, Crisp, & Gowers, 1989; Raboch & Faltus, 1991; VazLeal & Salcedo-Salcedo, 1992), as reviewed in Wiederman (Wiederman, 1996). Unfortunately, research conducted so far on this topic is not extensive. In a recent study (Pinheiro et al., 2010), which explored the sexual functioning of women with ED, although 87% of the women with ED were in a relationship, almost two thirds reported lack of libido and sexual anxiety. This problem with sexuality could be linked to a conflicting relationship with their body and a decreased ability to recognize their internal states. In other words, women with ED may struggle to identify themselves as sexually mature and able-to-conceive women.

In the earliest stages of pregnancy our participants expressed distress regarding the bodily changes they experienced. Smith (1999b) emphasises that in the early stages of pregnancy women (without an ED) are “vulnerable to uncertainties”. In a paper from Bailey (1999) the participants talk recurrently about the “unreality” of the experience, and the fact that they had to look constantly at their body to be reminded about the changes that were about to take place. For women with ED this experience can be particularly disruptive, on the one hand they feel uncomfortable with changes in their body, on the other, they are not yet identified with the mother-to be (Mason, Cooper, & Turner, 2012).

In the present study two domains: the old self (identified with the ED) and the new pregnant self were seen as opposite and irreconcilable by the participants. This is in line with the findings of Tierney et al. (2012) who found that women were caught between the demands of the ED and those of the pregnancy; in our sample there seemed to be no space for both. For women without an ED the same conflict has previously been described in relation to their professional identity (Hilfinger Messias & DeJoseph, 2007).

A subgroup of women with AN amongst the participants seemed to find a different strategy for coming to terms with what seemed a cognitive dissonance: although having a healthier eating pattern in respect to previous habits, they only accomplished the ‘necessary’ weight gain during pregnancy, and although apparently reaching a healthier BMI they remained in the anorexic BMI range. This could be

explained by the tendency towards denial displayed by women with AN: although they were aware of what a healthy BMI would be, they tended to apply a special cognitive schema for themselves, remaining egosyntonic with their own symptoms (Vandereycken, 2006). Moreover, for some of the participants, marginal improvements in their nutrition represented a good compromise between satisfying their ED and their sense of guilt towards the baby.

Late pregnancy in our sample seemed to be associated with a positive experience, with few exceptions. The views of others, and society at large, usually perceived as judgemental and critical, are now perceived as rewarding and gratifying. This is particularly important in women with ED who have been found to have difficulties with social/emotional processing, characterised by negative self evaluation, perceived inferiority etc. (Caglar-Nazali et al., 2014).

Pregnancy seemed to represent a sort of 'respite' phase from the ED, when women temporarily abandon their ED identity to embrace the new, maybe more fulfilling, and socially accepted mother-to-be identity.

In this context the post-partum seems to be perceived as a disruptive event. In line with Patel et al, (2005) women expressed discontent and deep dissatisfaction with their body; many experienced depressive symptoms. From their narratives a dimension of negative surprise and un-expectancy emerges. Previous authors have reported that mothers with ED often question their parenting ability (Patel. et al 2002), which could result in women with ED feeling less capable or "inferior" during the post-partum compared to other women.

The problem of identity seems quite compelling in this sample. As shown in the results section, most of the participants seemed to be deeply identified with their ED.

Many authors have analysed the pregnancy process (in women without ED) focusing on the self and the self-identity alterations, in particularly focusing on the body-self. Young (Young, 1984) stressed

the uniqueness of the phenomena taking place during this process, when one's identity as a body and the self is split, as the body from being an inner object becomes an external object.

In our study identity changes occurring during pregnancy assumed particular importance amongst participants. Various studies have suggested a possible early altered relationship in women with ED with their own selves, and consequently with their 'bodily-selves'. A study by Stein and Corten (2007) found that both patients with AN and BN had an impaired self-identity and a negative self-schema compared to controls. Moreover, women with ED were found to be less capable of describing their internal states and their emotions (Corcos et al., 2000; Lilenfeld, Wonderlich, Riso, Crosby, & Mitchell, 2006; Matsumoto et al., 2006; Eshkevari et al. 2012). One of the difficulties in treating women with ED is the fear that treatment 'can change their personality and sense of identity (..) with the implication of giving up a part of themselves, which can affect their decision' (Tan, Hope, & Stewart, 2003a, p. 546)

It is possible to hypothesize that for some of the women in this study, a pre-pregnancy vulnerable sense of identity led to a conspicuous investment in the transitional pregnancy-self. This is particularly relevant in view of the internal changes associated with pregnancy: changing of bodily sensation (i.e. appetite increase), hormonal changes, shifting from overvalued ideals (thinness, weight etc) to the baby's health and needs.

This could in turn contribute to reinforce the feeling of loss in the post-partum, concerning not only the pre-pregnancy self, but also the transient 'mother-to-be' identity (Upton, 2003), consequently endangering the delicate balance of a vulnerable time, when the woman is normally faced with the uneasy challenge of providing care and bonding with the new born.

An extreme example of this interpretation is participant 12 who very openly talked about her experience of the compulsion to become pregnant seven consecutive times, because she could not cope with not being pregnant.

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Compared to the first pregnancy, in subsequent pregnancies women seem now aware that the pregnant self is only transient and the demands of the ED prevail. Women appeared disenchanted in regards to the post-partum period and didn't feel compelled to change their ED behaviours in future pregnancies. Possibly women with ED choose to rely upon something that can guarantee them continuity: their ED identity.

### **Clinical implications and conclusions**

The first pregnancy for women with ED appears to be a particularly important and complex moment of transition. Women in our sample approached motherhood with doubts and fears, but were also very motivated to give themselves a chance to recover. Nevertheless, the powerful changes in the domain of the self and the body-self occurring in pregnancy can impinge on their journey to motherhood. Women with ED, having a vulnerable sense of self, might over-invest the 'pregnant identity' with negative consequences in the post-partum.

Early pregnancy is therefore an important window for women with ED to engage in treatment. During the early stages of pregnancy, women with ED might feel more vulnerable, experiencing an internal conflict to give up the ED and accept the transformation of their body. On the other hand they might be more motivated to challenge their behaviours as suggested previously (Micali & Schmidt, 2005). This especially appears to be the case for primigravidae.

An important finding to guide the treatment of women with ED during the perinatal period, is that women in this study recognized some protective factors, which helped them through the challenges of pregnancy and to overcome the impact of the post-partum, such as having received ED treatment in the past or during pregnancy and having the support of a caring and available partner.

Previous work has suggested that perinatal care should routinely include questions relating to body weight, eating and weight control behaviours in early pregnancy. Identification of this particular group of women can be difficult given the egosynonic nature of the disease combined with the feeling of

shame experienced by women with ED, leading to reluctance to disclose their disorder (Micali and Schmidt, 2005). Moreover lack of training and knowledge about ED among healthcare professionals can lead to underestimate the prevalence of ED symptoms (Easter et al., 2013).

As previously highlighted (Micali & Schmidt, 2005) it is of great importance to proceed promptly and assess carefully for ED symptoms when there is any concern amongst midwives or obstetricians. When an ED is suspected women should be offered adequate support during pregnancy, with a multidisciplinary approach that ensures continuity of care.

Moreover, women with ED should be monitored and helped to elaborate negative feelings and relapses in the post-partum. Many women in our sample experienced the recurrence of their ED symptoms after giving birth as a sign of their inadequacy as a mother, which in turn reinforced post-partum depressive feelings. Supporting women with ED in relation to their internal and external demands, and realistically preparing them for the challenges of the post-partum period, could ultimately help to prevent ED relapses or the onset of postnatal depressive disorders. This is particularly relevant given the importance the post-partum period has for both the wellbeing of mother and baby.

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Table 1: List of participants.

	Age at recruitment	Age of the child/children	Age of onset	Diagnosis	Recruitment method
Participant 1	24	1 baby, 8 months	11	Lifetime AN/BP. Current AN/BP	Perinatal Services
Participant 2	23	1 baby 2 year old	14	Lifetime AN/BP. Current AN/BP	ED Services
Participant 3	35	1 baby, 12 months	15	Lifetime AN/BP. Current BN	Perinatal Services
Participant 4	28	2 baby, 13 months, 2 years	14	Lifetime AN/BP. Current AN/BP.	Perinatal Services
Participant 5	28	1 baby 12months	14	Lifetime AN/BP. Current AN/BP	Perinatal Services
Participant 6	29	1 baby 30 years old	14	Lifetime AN/BP. Current AN/BP	Perinatal Services
Participant 7	29	1 baby 8 months old	13	Current BN	ED Services
Participant 8	26	2 babies 2 year old, and 4 year old	13	Lifetime An/BP. Current AN/BP	ED Services
Participant 9	38	4 children, youngest 2 year old, older 6 year old,	15	Lifetime restrictive An. Current AN/BP	ED Services
Participant 10	30	1 baby, 12 months	16	Lifetime AN/BP, Current BN	ED services
Participant 11	30	1 baby 12 months,	15	Lifetime BN, Current BN	ED services
Participant 12	39	8 children, youngest 2 year old	14	Lifetime AN/BP, Current AN/BP	ED services

Table 2: Overarching and Subordinate Themes.

Overarching theme	Subordinate theme
Approaching pregnancy	Not expecting to be pregnant
Early Pregnancy	A difficult transition
	Making space for the baby: the sacrifice of the ED identity
Middle to late pregnancy	Assuming the pregnancy identity: a new body to love
Post-partum	Loss of the pre-pregnancy body-identity, loss of pregnant-identity
Subsequent pregnancies	